SOME COMMON DIGESTIVE DISTURBANCES

By ANNE E. PERKINS, M.D.

ALTHOUGH "dyspepsia" is said to be obsolete as a scientific term, it is still often used, and "stomach trouble" and indigestion are as frequently heard. As a matter of fact, we now know from autopsies and operations that most so-called *stomach* troubles have their origin *outside of the stomach,* more especially in the gall-bladder and its ducts, appendix, liver, pancreas, and duodenum. There is often no disease of the stomach itself except some disorder of secretion, and it is obviously useless to drug this organ to excess when the acidity or pain is due to the appendix or liver. Ewald says that ninety-eight per cent. of all diseases with symptoms referable to the stomach originate outside the stomach.

There is too frequent a diagnosis of "nervous dyspepsia" with hyperacidity as a neurosis. The reflexes of the appendix to neighboring organs, through the sympathetic nervous system, are now recognized as causing pain and vascular disturbances. Pain in the appendix is often referred to the navel. The right ovary and appendix are often found to be diseased together, and in chronic appendicitis the pain is greatly aggravated at the menstrual period. Indigestion is said to be an American disease and seems to be on the increase because of our habits of hurry, hustling, irritability, and nervous tension. Irritability and indigestion are often retroactive; the more irritable one is, the worse the indigestion, and the worse the indigestion the more vicious the temper.

Osler says, "The chief causes of indigestion are dietetic, from unsuitable or improperly prepared food, persistent use of certain articles of diet, such as very fat substances, or foods containing too much of the carbohydrates, as hot bread, pies, pastry, excessive use of tea and coffee and alcohol, eating at irregular hours, or too rapidly, imperfect chewing, the use of ice-water. Excess in eating does more damage than excess in drinking. The platter kills more than the sword."

In dyspepsia we often see the extremes of overeating and starving. Many dyspeptics are greedy and lack self-control. They will say, "I ought not to eat this mince-pie," or whatever it is, but weakly eat it, or when suffering paroxysms, attribute it to this or that article of diet that "always nearly kills me." James G. Blaine said that nothing in his life taught him self-denial as did dyspepsia. On the other hand, people

may go on eliminating from their diet until they are not eating enough or a sufficient variety. Some feel that they should take a little something, even if they have an acute attack of indigestion, vomiting, and headache, which is, of course, a mistake. People should be taught that it will not hurt them to go without food for twenty-four, forty-eight hours or even much longer, but instead be a benefit to them, when a moderate fast is indicated. Upton Sinclair and his followers have demonstrated the lengths to which fasting can be carried.

We all see families that have insufficient nourishment and are bringing up children who are badly fed and nourished. These may be poor families who have no idea of food values and spend a great deal more than they can afford for food and yet do not have wholesome, nourishing food. With less expense they could live better by choosing cheaper cuts of meat and cooking it by suitable methods, by using more rice, cereals, cornmeal, milk, dried peas, etc. How often we see them buying bakers' truck, high-priced fruits, expensive meats, and badly cooking what they buy, allowing the children tea and coffee. In Colorado the high-school girls are taught to buy food in market as well as to prepare and cook it.

It is by no means the poor families alone who are poorly fed and nourished. All of us have in mind families that can afford an ample diet, that have food atrociously cooked, without any idea of nutritive values. People are so ignorant of dietetics that it is not enough to say vaguely to a patient, "*Be careful in diet,*" we must give a *diet-list, what to eat, how to cook it,* and add forbidden articles also. We may eat too much and yet not extract enough for proper nourishment, if it is the wrong kind of food. Osler says we should ask every dyspeptic two questions, the time he takes at meals and the amount he eats. Hasty and imperfect mastication and overeating cause the majority of cases of indigestion, as seen in the "restaurant dyspepsia" of business men, who eat lunch hastily and often after a drink, hasten back to the office, and in waitresses who eat in hasty snatches between trips to the dining-room.

In summer, if too much or unsuitable food is taken, especially in very hot weather, it is likely to be undigested and ferment, particularly if a large amount of acid berries has been taken.

Alcohol can hardly be overestimated as a cause of chronic dyspepsia. The majority of people with dyspepsia cannot understand why they cannot eat anything and take a "pill after pie" that will digest the most unsuitable food, and keep on eating recklessly until digestion is permanently disturbed, with changes in the amount and character of the digestive juices. Food is retained too long and the muscular coat of the stomach becomes weakened, there are fermentation, flatulence

and acidity, with waterbrash or pyrosis, a rising to the mouth or spitting up of a sour or bitter fluid. The appetite varies from none to voracity. There is an ill-defined distress after eating, a fulness and discomfort or actual pain and soreness over the stomach, so that even ordinary clothing cannot be borne but must be loosened. Often there is a feeling as if a stone lay in the stomach and pain radiated from it. There is a bad taste in the mouth, "heart-burn," and perhaps eructations of gas, and bloating from gas in the intestines, often accompanied with palpitation of the heart. The person who has dyspepsia is notably tart, savage, gloomy, "blue," and constantly out of sorts and unfitted for his work. There are likely to be bad dreams or nightmare, often dreams of much food set before him, with a feeling of nausea, so that he wakes feeling unrefreshed and conscious of some uneasiness in the stomach.

Melancholia comes from two Greek words meaning black bile, which shows that even in old times it was a recognized fact that whether life is worth living or not depends on the liver and digestion. Sick-headaches are common and the so-called bilious attacks of the laity. With some the trouble does not seem to be aggravated by any particular element or food-group, but generally the small intestine is the offender rather than the stomach, and it is the *starches* that cause the most trouble, but sometimes all three of the food-groups, fats, proteids and starches, are not well digested. It is astonishing that people with a "weak stomach" will eat pancakes drenched with syrup, sausages, rich heavy cakes and pastry, fried eggs, stewed tomatoes, bananas, strawberries, half a pound of candy, coffee and cereal together, cheese, mince pie, boiled cabbage, etc. Of course "one man's meat is another's poison" and some eat lobster and welsh rabbit with impunity. In general one must forbid all these things and exclude the coarser vegetables as turnips, carrots, cauliflower, etc. *Tea* is a very great factor in the dyspepsia of women; they wash down a little bread or toast with tea, and too often the tea has stood on the grounds or been warmed up and the toast has the butter fried into it until it is indigestible. Frequently, increasing the out-of-door exercise, and daily twenty-minute gymnastic exercises are helpful in strengthening digestion and overcoming the constipation nearly always present. The digestive ferments so widely given are nearly always useless or unsatisfactory, but taka-diastase at times seems to control somewhat the excessive flatulence. Lavage is helpful, or the drinking of hot water with or without soda bicarbonate.

Generally speaking, hygiene and dietetic measures are more helpful than drugs. It is now well known that we were formerly at fault in diagnosticating gall-stones too late, after gall-stone colic and jaundice

occurred from the passage of a gall-stone or the stoppage of the cystic or common bile duct. Most cases do not have the sudden classical onset of colic, vomiting, jaundice, etc., without the history of years of long-standing dyspepsia, "neuralgia of the stomach," chronic appendicitis, constipation, marked flatulence, variable appetite, discomfort and soreness or fulness in the stomach and liver regions, independent of food taken, or even *worse when the stomach is empty.* In 90 per cent. of cases we find the old classical symptoms of colic and jaundice do not occur early or often never appear at all. But a careful questioning will reveal that the general health has suffered, with symptoms as mentioned. Often appendicitis and gall-stones occur together, and very often follow typhoid on account of the predilection of bacteria for the gall-bladder. The pain of gall-bladder disease is a peculiar dragging ache or heaviness in the region of the gall-bladder with soreness in the region of the liver and a pain or ache extending to the angle of the right scapula, a soreness at the level of the twelfth dorsal vertebra extending to the posterior axillary line on the right. This is worse two or three hours after eating and worse after certain articles of food are taken that produce fermentation or gastric disturbances. Coffee and alcoholics are badly borne, as are rich dishes, salmon, pastry, sweets, hot breads, cheese, etc. Nausea is a frequent symptom; and one of the most important symptoms, present in 70 per cent., is *hyperchlorhydria, i.e.,* an increase in acidity of the gastric juice, caused by an excess of hydrochloric acid. A common symptom is the gnawing feeling in the epigastrium that comes on at certain times, as *within two or three hours after breakfast, and at night.* There is belching of gas, soreness on pressure over the gall-bladder, marked by hypochondriasis, pain often referred to a point below the ensiform cartilage, instead of the liver, worse at night. These cases are the earlier or milder ones and can be treated by hygienic, dietetic and medical treatment. When we have severe cases with agonizing pain and recurrent colic, with or without stones in the stools, it is a *surgical* condition which should have been recognized earlier. The reason we overlook gall-stones so often is because we have been drilled into expecting jaundice and enlargement of the gall-bladder. Those of you who recall the formation of the common bile duct will readily see that the bile is not shut off from entering the intestine unless the stone is lodged in the *common bile duct* for some time, for if it is in the gall-bladder or cystic duct, there are still the hepatic and common bile ducts free, and hence no jaundice. Bearing in mind these symptoms, we must be on the alert to diagnosticate gall-stones without jaundice or tumor and sometimes without pain or being able to find stones in the stools.

At least 20 per cent. of the autopsies on the insane show the presence of gall-stones which have rarely caused colic or been recognized. Doubtless there are countless cases diagnosed as acute gastritis, bilious attacks, indigestion and appendicitis. I have heard physicians who had practised for years say they had never met a case of gall-stones,—obviously, they had not recognized them. Ten to twenty per cent. of all old people who come to autopsy have gall-stones, often not troublesome. The etiology is an infection of the gall-bladder by certain bacteria, notably the colon bacillus and typhoid, probably through the portal circulation, and as a result of cholecystitis, gall-stones form. Sedentary habits, drinking too little water, pregnancy and constipation foster their formation. Because they are five times as frequent in women as in men, it is said that constriction by corsets pushes the liver in and upwards and causes stagnation of bile. Gall-stones rarely occur before 20 years of age, are frequent from 25 to 30 in women and the majority have the first attack before 35. It is a popular fallacy that they can be *dissolved* in the gall-bladder—this is absolutely without foundation.

(*To be continued.*)

THE MODERN SURGICAL NURSE

By GEORGE S. FOSTER, M.D.

Manchester, N.H., Surgeon and Pathologist to the Hospital Notre Dame de Lourdes; Assistant Surgeon to the Beacon Hill Hospital

In this age of progress in scientific methods the nursing profession comes in for its share of benefits. Each year sees rapid changes in the way of revolutionizing nursing methods, and the nurse who has been well prepared will, after some years of practice, take a post-graduate course, as high ideals always lead to higher study. Thus she places herself in the world of specialists, and finds her labors leading her toward the operating room, the obstetrical bed, fever patient, chronic wheel-chair patient, or infant. Many nurses enter the profession for a general all-round training and later select the path for which they deem themselves most fitted.

This last fitness is made more complete by the advantages of the post-graduate courses now at the command of the progressive nurse. In other words, we have to-day a nurse who seems to best understand the care of a fever case, and a nurse who excels when watching a surgical case. It is this last class of special nurses to whom I, not, however,